Department of Medical Assistance Services
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Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Nursing Facility and Hospice Providers Participating in the Virginia Medical Assistance Program and Commonwealth Coordinated Care (CCC) Managed Care Plans

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 7/26/2016

SUBJECT: Occurrence Code 50 Billing Edit

The purpose of this memo is to inform providers that DMAS is implementing an edit for nursing facility claims with at least one non-default Resource Utilization Group (RUG). This edit requires that: (1) the number of Occurrence Code 50s (with a valid begin date) on a claim match the number of non-default RUGs associated with a revenue code 0022 and (2) at least one begin date for the Occurrence Code 50s is within 150 days of the from date of service on the claim and not more than 30 days after the from date of service on the claim. This date should be the assessment reference date (ARD) used to determine each non-default RUG code.

Occurrence Code 50 Edit

Appendix F of the Medicaid Nursing Facilities manual requires "nursing facilities to report the ARD with the Occurrence Code 50 for each RUG code reported in the [first 3 digits of the] HIPPS Rate Code field on the UB-04. The date of service reported with Occurrence Code 50 must contain the ARD associated with the applicable OBRA [Omnibus Budget Reconciliation Act of 1987] assessment. An Occurrence Code 50 is not required with the HIPPS code reported for default RUG AAA."

The new edit will check that the number of Occurrence Code 50s are equal to or greater than the number of revenue codes 0022 with a non-default RUG. In addition, the begin date for the required number of occurrence codes must be a valid date.

OBRA requires that patients are assessed every 92 days unless there is an applicable exception for a discharge and readmission. In addition, OBRA requires that the Minimum Data Set (MDS) be completed no later than 14 days after an admission, significant status change or transfer. The 14 days include the maximum observation ("look back") period as well a grace period allotted to complete the assessment. In order to accommodate these exceptions, the begin date associated with at least one Occurrence Code 50 must be within 150 days of the from date of service and not more than 30 days after the from date of service.

The edit will deny claims that do not meet these requirements. However, the edit does not fully review compliance with the OBRA rules. Approved nursing facility claims are still subject to post payment review to further validate that the RUG code complies with the OBRA rules and the applicable time

frames. For any period that there is no valid RUG according to OBRA rules, the nursing facility should bill the default RUG AAA.

Each claim will be evaluated for compliance during claims adjudication beginning with claims processed on or after August 1, 2016 for dates of service on or after July 1, 2015. Claims will not be reprocessed but any adjusted claims for dates of service on or after July 1, 2015 will be processed with these edits. Claims that do not meet these requirements will deny for reason code 1736 (Occurrence Code 50 Not Present). Table 1 provides example scenarios for Edit 1736:

Table 1: Edit 1736 Scenarios

From Date of Service	RUG	Occurrence Code 50 (ARD Date)	Edit Result	Explanation
09/01/2016	RAD	Occurrence Code 50: (07/01/2016) Occurrence Code 50: (invalid/missing end date)	No edit Claim will pay	ARD is within 150 days of from date of service.
09/01/2016	RAD	Occurrence Code 50: (01/01/2016) Occurrence Code 50: (07/01/2016)	No edit Claim will pay	One ARD is within 150 days of from date of service.
09/01/2016	RAD	Occurrence Code 50: (01/01/2016)	Edit 1736 Claim will deny	ARD is not within 150 days of from date of service.
09/01/2016	RAD	Occurrence Code 50: (09/29/2016)	No edit Claim will pay	ARD is within 30 days after from date of service.
09/01/2016	RAD	Occurrence Code 50: (10/02/2016)	Edit 1736 Claim will deny.	ARD is more than 30 days after from date of service.
09/01/2016	RAD SE2	Occurrence Code 50: (07/01/2016) Occurrence Code 50: (invalid/missing end date)	Edit 1736 Claim will deny	The number of non-default RUGs must equal the number of Occurrence Code 50s with a valid date.
09/01/2016	RAD SE2	Occurrence Code 50: (07/01/2016)	Edit 1736 Claim will deny	The number of non-default RUGs must equal the number of Occurrence Code 50s.
09/01/2016	RAD SE2	Occurrence Code 50: (01/01/2016) Occurrence Code 50: (07/01/2016)	No edit Claim will pay	One ARD is within 150 days of from date of service.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a managed care program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

MANAGED CARE PROGRAMS

Many Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.